Request for Service Credit Cost Information — Leave of Absence

888 CalPERS (or **888**-225-7377) • TTY: For Speech & Hearing Impaired (916) 795-3240

Name of Member (Last Name, First Name, Middle Initial) | Social Security Number — —

Section 1 About You

Have you requested this cost information before? ☐ No ☐ Yes Requested Date (mm/dd/yyyy)

Have you submitted a retirement application? ☐ No ☐ Yes Retirement Date (mm/dd/yyyy)

Former Name (if applicable) | Current Employer

Mailing Address

City | State | ZIP Code | Daytime Phone

Section 2 Employment Information

List the name and address of the employer that granted the leave.

Employer

Address

City | State | ZIP Code

List the dates and type of leave for each period requested.

Types of Leave
Maternity/Paternity, Temporary Disability, Educational, Service, Sabbatical, Employee's Own Serious Illness

Dates of Leave From (mm/dd/yyyy) | To (mm/dd/yyyy) | Type/Purpose of Leave

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Section 3 Certification

Give the form to the employer that granted the leave to complete Section 4 (and to route to the compensation carrier to complete Sections 5 and 6).

Member Signature | Date (mm/dd/yyyy)

Section 4 Leave of Absence Certification (to be completed by employer)

Employer: Return the completed form to the member or forward it to the employee's Workers' Compensation carrier, as appropriate.

Dates of Leave From (mm/dd/yyyy) | To (mm/dd/yyyy) | Type/Purpose of Leave

I hereby certify that the above information is true and correct. If leave was for Serious Illness, I further certify that the period was an uncompensated leave of absence approved for the employee's own serious illness.

Employer Signature | Title | Date (mm/dd/yyyy)

Printed Name | Daytime Phone | FAX

Put your name and Social Security number at the top of every page.

Name of Member (Last Name, First Name, Middle Initial) | Social Security Number — —

Section 5

Temporary Disability Leave of Absence Certification

To be completed by the Workers' Compensation carrier that provides temporary disability benefits.

Workers' Compensation Carrier Information

Name of Employer's Disability Carrier

Carrier's Address | Carrier's Phone Number

Employee's Claim Number* | Beginning Date of Temporary Disability Payments (mm/dd/yyyy) | Ending Date of Payments (mm/dd/yyyy)

Effective Date of Permanent Disability Rating*

* If there was more than one temporary disability leave period, provide claim numbers and dates for each.

Was there a settlement by Compromise and Release? ☐ No ☐ Yes. Provide copy.

Section 6

Signature of Authorized Workers' Compensation Carrier Representative

Please return this request form to the member.

I hereby certify that the above information is true and correct.

Carrier Signature | Date (mm/dd/yyyy)

Printed Name | Title

Mail to: **CalPERS Member Services Division** • P.O. Box 4000, Sacramento, California 95812-4000